



Medicalisation and participation in legal capacity determinations in Chile

Pablo Marshall^{a,*}, Guillermo Jiménez^b

^a Universidad Austral de Chile, Chile, Campus Isla Teja s/n, Valdivia, Chile

^b Universidad Adolfo Ibáñez, Chile, Padre Hurtado 750, Viña del Mar, Chile

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ABSTRACT

This paper provides an examination of the process used by ordinary courts in Chile when making legal capacity determinations. It provides an up-to-date account of various aspects of law and procedure related to legal capacity in this jurisdiction. Also, by drawing on semi-structured interviews with judges, this paper examines judicial understandings of legal capacity decision-making focusing on problems related to the medicalisation of mental disability and the participation of persons with disabilities in legal capacity procedures.

1. Introduction

Legal capacity determinations are currently attracting much criticism in the world of human rights law. The right to equal recognition before the law, entrenched in Article 12 of the Convention on the Rights of People with Disabilities (CRPD), has strongly affected the debate on legal capacity (Series & Nilsson, 2018). Legal capacity is a legal concept identifying the condition of being the holder of rights and duties (legal subject), but it also refers to the capacity to exercise those rights and serve those duties, thus to be able to modify legal relationships (legal agency). Legal capacity models have been developed along certain conceptual binaries, such as capacity and incapacity, autonomy and paternalism, and empowerment and protection (B. A. Clough, 2018). In these models, full legal capacity, including legal agency, has traditionally been denied to individuals who are unable to act autonomously or are in need of protection because of an impairment of the mind. This approach to legal capacity has come to be known as a *status approach*. It is intimately linked to the institution of adult guardianship, in which a third person is judicially appointed to make decisions about the person deemed to lack capacity. Certain jurisdictions have shifted towards a *functional approach* to legal capacity, in which a more focused and precise examination is made to determine whether a person understands the meaning and consequences of the decision relating to a particular issue at the relevant time. In this approach the person retains the status of

legal agent, and the incapacity judgment only covers a specific decision which is to be made by a third person (Quinn & Arstein-Kerslake, 2012, pp. 44–46).

The text of Article 12 of the CRPD has challenged these widely-accepted approaches to legal capacity, emphasising the role of relationships of support and demanding the recognition of legal capacity for persons with disabilities in equal terms (Flynn & Arstein-Kerslake, 2014b; Series, 2015). This challenge has resulted in the incorporation of supported decision-making, as a mechanism to protect the autonomy of persons with disabilities and facilitate their exercise of legal capacity. It has also resulted in demands to abandon the widespread use of substitute decision-making (Arstein-Kerslake, 2017; Bach & Kerzner, 2010; Gooding, 2017). In the literature, some authors have interpreted Article 12 of the CRPD – along with the General Comment N° 1 of the Committee on the Rights of the Persons with Disabilities (2014) – as recognising a new approach, according to which legal capacity is treated as a universal right completely detached from the person's decision-making performance and functionality. Consequently, they demand the abolition of every instance of substitute decision making and the end of capacity assessments (Arstein-Kerslake & Flynn, 2016; de Bhailís & Flynn, 2017; Flynn & Arstein-Kerslake, 2014a). However, others have defended a more nuanced approach which admits the possibility of a functional approach to legal capacity under the CRPD (Donnelly, 2016; Martin et al., 2016; Martin, Michalowski, Jütten, & Burch, 2014; Ruck Keene,

* Corresponding author.

E-mail addresses: pmarshall@uach.cl (P. Marshall), guillermo.jimenez@uai.cl (G. Jiménez).

Kane, Kim, & Owen, 2019). This is an ongoing debate unlikely to be resolved in the coming years (Craigie et al., 2019; Flynn, 2019; Szmukler, 2019).

Despite the fact that certain legal communities have resisted the idea of abandoning regimes of capacity assessments and guardianship (Series, 2014, pp. 108–109; Fallon-Kund & Bickenbach, 2016, p. 30),¹ the notion of legal capacity as a human right is having an important impact on legal capacity reforms worldwide (Fallon-Kund & Bickenbach, 2017). Particularly in South America, reforms in Argentina (2015), Peru (2018) and Colombia (2019) have transformed general regimes of guardianship into regimes of support for the exercise of legal capacity, following the recommendations of the CRPD Committee (Martinez-Pujalte, 2019). Other jurisdictions, such as the Republic of Ireland (2015), Northern Ireland in the United Kingdom (2016) and Victoria in Australia (2020) have updated their legislation, keeping the functional approach but attempting to limit discrimination against persons with disabilities (Flynn, 2020; Harper, Davidson, & McClelland, 2016; Watson, Anderson, Wilson, & Anderson, 2020). Academic and policy debates on legal capacity reform have drawn heavily on the themes of protection and autonomy to discuss whether paternalistic interventions may be justified in some circumstances (Fallon-Kund & Bickenbach, 2016, p. 31; Fallon-Kund, Coenen, & Bickenbach, 2017, pp. 70–71). Scholars point out the varied and serious negative effects that may follow from a determination that someone lacks legal capacity (Case, 2019, p. 309; Series, 2014, p. 108).

However, it is common for legal reform proposals based on Article 12 of the CRPD to adopt an approach that is mainly focused on the substantive aspects of legal capacity, and that only marginally delves into the procedural aspects of capacity determinations or support needs assessments (Fallon-Kund & Bickenbach, 2016; Series, 2014; Series, Fennell, & Doughty, 2017; Watson et al., 2020). This may be explained by the emphasis on the abolition of such procedures in academic commentaries about Article 13 of the CRPD, which addresses access to justice for people with disabilities (Flynn, 2015, Chapter 4; Weller, 2016). Determining who can participate in such procedures and in what way, what evidence is considered to make capacity determinations, and on which values and motivations judges base their decisions can have massive impact on the effectiveness of reforms. Legal capacity reforms have increased the participation of people with disabilities in procedures dealing with their interests, but there is also evidence that these reforms have limited impact without a careful procedural design (Fallon-Kund et al., 2017; Fallon-Kund & Bickenbach, 2016). There is no direct evidence of the Latin American experience in this regard, but the lack of procedural reforms complementing substantive reforms may be an indication of the potential outcomes.

This paper examines the legal capacity determination procedure in Chile. We examine the law and procedure surrounding legal capacity in this jurisdiction, which centres on a quasi-judicial, non-adversarial procedure whose purpose is to fast-track determinations of legal capacity based on evidence provided by an expert administrative agency in charge of determining “mental disability” for social security purposes. Since its introduction in 2004, this procedure has become more commonly used. Lathrop (2019) and Marshall (2020) have used doctrinal analysis to argue that Chilean legislation is not compliant with

¹ Article 12 was the object of numerous reservations and declarations regarding the compatibility of the CRPD text with the continued existence of substitute decision-making instances, including from Australia, Canada, Egypt, France and the Netherlands (see https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-15&chapter=4, accessed 30 June 2021) Likewise, during the elaboration of the General Comment N° 1, the CRPD Committee received critical comments on the first draft, in relation to the prohibition of certain instances of substitute decision making, from Denmark, France, Germany, Norway and New Zealand (See <https://www.ohchr.org/en/hrbodies/crpd/pages/dgcarticles12and9.aspx>, accessed 30 June 2021).

CRPD standards. Departing from that approach, our analysis is based on a preliminary socio-legal study of judicial decision-making. This empirical research enabled us to gain insight into how judges conceive their role in legal capacity determinations. We analyse our empirical observations in light of recurrent themes found in the legal and mental capacity literature. Based on our study, we concentrate on two aspects that are inescapable in the functioning of judicial decision-making on legal capacity. First, we examine the problem of medicalisation of judicial decisions in this area. This problem relates to judges’ conceptions about their role vis-à-vis the medical domain. Medicalisation of legal capacity determinations remains an unexplored theme in civil law jurisdictions, but has been explored in Case (2016) and Lindsey (2020) in relation to functional mental capacity assessment procedures before the Court of Protection (CoP) (England and Wales). Our discussion of our results draws on their insights. Second, we examine the problem of the participation of persons with disabilities in procedures that may adversely affect them. In this regard, our research complements previous published research by Series et al. (2017), Case (2019) and Lindsey (2019) addressing the same issue in the procedures before the Court of Protection (CoP), and by Fallon-Kund and Bickenbach (2016) and Fallon-Kund et al. (2017) in European jurisdictions which made reforms following the CRPD but maintain some instances of guardianship.

These themes are not only critical in current Chilean procedures, but will also be crucial in future reforms within this field, in Chile and abroad. Regardless of the content of substantive legal capacity law, there is an urgent need to address the problems of medicalisation and participation of the person whose capacity or support needs are being assessed, to ensure that we are using a rational and respectful decision-making process. We believe that gaining knowledge about the functioning of current legal capacity determination procedures in unreformed legal jurisdictions may allow us to identify challenges posed by procedural design that remain unnoticed by reformers. Notably, some of these challenges could greatly impact the success of legal capacity reform.

The paper is divided into three main sections. In Section 2 we briefly describe our methodology and sample. In Section 3, we then explain the legal context in which the procedures being studied take place. This section describes recent changes in Chilean legislation and the main formal features of the fast-track procedure for legal capacity determinations. In Section 4, we discuss our conclusions from interviews with judges who have conducted legal capacity procedures. We discuss judicial views on the evidence produced by the Chilean disability agency (Compin), as well as their experience conducting the hearings in which judges can personally interact with persons with disabilities, in light of recent theoretical literature on the medicalisation and participation of persons with disabilities in legal procedures.

2. Methodology

To gain insight into the actual operation of the fast-track procedure for legal capacity determination, we conducted empirical qualitative research based on semi-structured interviews with judges. Our main goal was to understand how judges were assessing “insanity” to determine legal capacity and put a person into guardianship. We particularly focused on two factors: (1) the value judges accord to expert evidence contained in a certificate issued by the Preventive Medicine and Disability Commission (*Comisión de Medicina Preventiva e Invalidez, Compin*) and (2) how they interact with persons with disabilities during these hearings. Through these elements, we sought to explore how evidence is considered and included in the procedure, the degree of coordination between administrative agencies and the courts, the degree of medicalisation of legal capacity decisions, and whether persons with disabilities are duly heard.

Data were collected between December 2018 and June 2020. Data collection was conducted by both authors in two Chilean regions. Semi-structured interviews were conducted in order to gain a broader

understanding of judicial decision-making. As shown in Table 1, interviews were conducted with five judges from the first region and three from the second region. Interviews lasted for up to 40 min. Our eight interviewees were all working as civil judges at the time of the interviews. Four were men and four were women. The years of experience as a judge at the time of interview ranged from 5 to 20 years. Participating judges were contacted using a purposive snowball sampling approach. We sought judges with extensive experience in legal capacity determination. We initially contacted one judge in each region, which subsequently led us to the rest of the sample; this continued until we reached data saturation, since interviewees shared similar experiences and themes became recurrent. All interviews were recorded and transcribed. Notes were also taken during informal conversational interviews. Participants were first asked to explain their background as judges and their experience related to legal capacity procedures in particular. We then asked them to describe how legal capacity hearings were conducted in their tribunals. Furthermore, we asked them about their understanding of the mental disability assessment process before Compín and how they make judgements of the certificate issued by Compín. We concluded by asking the judges about their specific knowledge related to the CRPD.

We invited the participating judges to take part in our research and provided basic information about the study, such as the research purpose and absence of risks. If they wished to take part, we guaranteed anonymity and the possibility to withdraw from the study at any time. Finally, they were invited to voluntarily indicate their informed consent by signing a consent form. An application was filed with the Ethics Commission of Universidad Austral de Chile, which approved the research.

3. Legal background

The current scheme of legal capacity determinations for persons with disabilities in Chile considers two procedures in which a determination can be adopted. In this section, first, we explain the traditional substantive and procedural legislation related to the legal status of “insanity”, which requires the revocation of the presumption of an adult’s legal capacity and the appointment of a guardian. Then, we turn to more recent legislation which introduced a bridge between the traditional legal category of “insanity” and the modern notion of “mental disability”. To understand this bridge, we describe the functioning of an administrative procedure used to determine mental disability for social security purposes. Finally, we focus on how a new quasi-judicial procedure uses disability assessments to fast-track legal capacity determinations.

Table 1

List of interviewees.

Date	Judge number	Region of Origin	Background
28.09.2019	Judge 1 (J1)	Los Ríos	Male - 20 years' judicial experience
16.08.2019	Judge 2 (J2)	Los Ríos	Male - 10 years' judicial experience
14.10.2019	Judge 3 (J3)	Los Ríos	Female - 11 years' judicial experience
15.10.2019	Judge 4 (J4)	Los Ríos	Female - 10 years' judicial experience
23.10.2019	Judge 5 (J5)	Valparaíso	Female - 23 years' judicial experience
24.10.2019	Judge 6 (J6)	Valparaíso	Male - 15 years' judicial experience
11.6.2020	Judge 7 (J7)	Los Ríos	Male - 12 years' judicial experience
17.6.2020	Judge 8 (J8)	Valparaíso	Female - 13 years' judicial experience

3.1. Legal capacity and guardianship in the civil code

The main rules on legal capacity are set out in the 1857 Civil Code, and reflect a traditional binary conception of legal capacity. On the one hand, there is a presumption of legal capacity for adult persons. On the other hand, the declaration of “insanity” (*demencia*) transforms someone’s status into “absolutely incapable” (Article 1467). Although the Code does not define “insanity”, this concept has been understood by private law literature as the state of a person who cannot govern themselves due to impaired judgment (e.g. Corral, 2011). This vague notion has obvious overinclusive implications for persons living with mental disability. Since it does not provide a structured standard for judicial determinations, it leaves ample space for judicial discretion and prejudices.

An ordinary private law court oversees the paper-based procedure used to declare “insanity”, and consequently to appoint a legal guardian. This takes the form of an extended adversarial trial, a procedure that is usually used to make determinations on complex private law issues. While the allegedly “insane” person will be the defendant in the procedure, the plaintiff may be a member of their family. The law requires that to make the legal capacity determination the judge must “be informed of the previous life and habitual conduct of the alleged insane person and hear the opinion of doctors of their confidence about the existence and nature of the insanity”. A final judicial decision declaring a person “insane” has the effect of permanently depriving that person of the “administration of his property” (Article 456). Any future actions of the person will generally be regarded as lacking legal effect.

In line with other jurisdictions (Fallon-Kund et al., 2017; Frolik, 1999), Chilean private law doctrine conceives the judicial declaration of “insanity” in relation to guardianship as a measure of protection. From this perspective, after the judicial intervention, the “insane” person will be protected from the risks posed by their impaired judgment. Their guardian’s full capacity will protect the person from abuse from third parties and self-harm (e.g. Corral, 2011).

3.2. Disability assessment for social security purposes

In parallel to the regulation of legal capacity in the Civil Code, modern legislation has introduced an administrative procedure to grant rights and social benefits to persons with disabilities. Departing from the vague and archaic concept of “insanity”, this modern legislation uses the concept of mental disability, which is defined in broad terms, in line with the CRPD, and requires a multidisciplinary assessment. In 1994, Law 19,284 (on the integration of people with disabilities) granted new rights and social benefits to persons with disabilities in Chile. Along with this social security scheme, an administrative procedure was introduced to assess the type and degree of disability and determine a person’s entitlement to disability rights and social benefits. This administrative procedure is the responsibility of the Commission of Preventive Medicine and Disability (Compín) and includes a biopsychosocial evaluation performed by a health service, which must include (1) a biomedical-functional evaluation report (from a medical doctor), (2) a self-diagnosed performance report and (3) a social and support network report (from a social worker). The Compín certification committee, which is chaired by a medical doctor and composed of a psychologist, a speech therapist, a social worker and a special or differential educator (or a kinesiologist or occupational therapist), rechecks and certifies the report. Once the disability is certified, the person is automatically enrolled in the National Registry of Disability, which issues a certificate of disability. The assessment of persons with mental disabilities is further regulated by Law 18,600 (on the mentally handicapped) of 1987 (modified in 2001). Despite some minor differences, the assessment of mental disabilities remains the same as the general procedure. Notably, the procedure takes no longer than 30 days.

3.3. Connecting disability and legal capacity

In 2004, Law 19,954 introduced a new fast-track judicial procedure to declare “insanity”, thereby complementing the Civil Code procedure. Unlike the old lengthy and adversarial procedure, the new procedure was designed to be non-adversarial and expeditious. According to legislative reports, the introduction of this procedure had a two-fold objective: (1) avoiding protracted delays and (2) facilitating the appointment of a guardian (BCN, 2004). This reform reacted to one of the main criticisms against the old procedure: its adversarial nature delayed proceedings, despite there being no real dispute or controversy in the majority of cases. In practice, family members participated in proceedings as plaintiffs and also supported the defendant (CAJ, 2012).

The non-adversarial nature of the new procedure aims to fast-track legal capacity determination. This is achieved by reducing the complexity of the procedure and limiting the evidence that needs to be provided. The key aspect of the new procedure is to link the certificate of mental disability issued by Compin to the legal capacity determination, making the former a legal condition of the latter in the new procedure. Although the original bill included an automatic legal incapacity determination based on the Compin certification of mental disability, during the legislative process a change was introduced to incorporate “the intervention of a judge, who can appreciate that the person is indeed in the position of being declared insane, but without a long procedure, due to the existence of the previous administrative assessment of disability” (BCN, 2004, p. 15). Thus, the final bill passed by Congress combined the increased speed enabled by the Compin certification with a guarantee that a judge will verify that the person is effectively “insane”, hearing the person with a disability.

This procedure begins with a relative of the person with disability submitting a written request for a declaration of “insanity” and the appointment of a guardian before the court. Given the non-adversarial nature of the procedure, the petitioner is the only party and the person with disabilities is not formally recognised as a party. Immediately after the first submission, the court summons the petitioner to a hearing, at which they should appear in court with the person with disabilities. Finally, the court accepts or rejects the request.

Given the greater ease and speed with which the declaration of legal incapacity for “insanity” is made, this new procedure is used in over 85% of legal capacity determination cases that seek to declare “insanity” and appoint a guardian.²

4. Results

In this section, we focus on medicalisation and participation as two central aspects of legal capacity determinations in Chile. Using the results of a set of interviews that we conducted with judges in two Chilean regions to inquire about their practices, we discuss how the legal procedure used in Chile has affected the rights of persons with disabilities. We found that the current scheme has increased the risk of medicalisation, as the judges see the evidence as primarily medical, and are dubious about their role in scrutinising the evidence provided by an external institution such as Compin. As to participation, we found that the mandatory hearing that the law requires to make a legal capacity determination is not actually used to provide a forum for genuine engagement with the persons with disabilities. The regulatory setting in which the judges operate impedes the judges from using this procedural device as an opportunity to hear the voices of the persons being declared “insane”.

² We base our estimate on data obtained from the Chilean judicial power website (<http://basejurisprudencial.poderjudicial.cl>, accessed 30 June 2021). Between 2011 and 2019, courts issued 7857 decisions on “insanity”, 6757 of which were the result of procedures based on the Compin certificate.

4.1. Legal judgment and medical expertise

4.1.1. Expeditiousness and medicalisation

To what extent is legal capacity determination in Chile under the 2004 scheme a medicalised practice? We understand medicalisation as the process of treating a problem as medical when it was previously addressed as non-medical. Since medical categories can expand and contract, it is possible that problems previously considered medical can escape from medical jurisdiction or conceptualisation through the process of demedicalisation (Conrad & Bergey, 2015). The problems affecting persons with disabilities are not necessarily related to bodily impairment but with their (relational, social, economic, etc.) environment. A key aspect of disability demedicalisation is the inclusion of other sources of knowledge in its conceptualisation and determination – crucially, knowledge provided by the experiences of the very persons affected by disabilities (Shakespeare, 2006). The extensively cited General Comment 1 of The Committee on the Rights of Persons with Disabilities uses the following argument to directly attack the medicalisation of legal capacity assessments: “Mental capacity is not, as is commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity” (par 14).

An important feature of the Chilean fast-track procedure introduced in 2004 is the innovation in the form in which expert evidence is introduced in the decision-making process. Our study reveals that this feature has exacerbated the medicalisation of the process under the current scheme. Overall, our interviewees had a very clear idea of the 2004 reform. Some of them contrasted their experiences conducting the old, cumbersome procedure with the new, more agile, non-adversarial procedure (J3). Interviewees generally valued the procedural change, since people used to wait a long time for an outcome equivalent to that of the new procedure on every account (J1 & J5). Interviewees also felt that the change facilitated a more timely procedure whose ultimate aim was to provide a social welfare service that generally benefits poor people (J2, J3, J4, J5, J6, J7 & J8). According to them, this was the main purpose of the reform. Notably, they see themselves as bound to make this goal of expeditiousness operative (J5 & J6).

However, worsened medicalisation was the price to be paid for a more agile procedure. In fact, judges understand the role of the Compin certificate as providing a degree of medical expertise in the process. They viewed the administrative procedure before Compin as a pre-trial in which an expert institution discharges a function formerly assigned to judges. In the judges’ words, this function consisted of determining “disability” and “insanity” (J1 & J3). Since they understand that this is a medical determination above all, judges found it normal that this role was transferred from the judicial to an administrative agency (J5). Although they hesitated when asked what the purpose of the Compin procedure was, most eventually stated that it was mainly to certify that a person required social assistance for a disability (J2 & J8). However, several interviewees thought that the primary goal of the administrative procedure was to prepare the case for the final judicial determination of legal capacity, despite knowing that this was not its only aim (J2 & J6). Ultimately, judges interpreted the changes introduced in 2004 as removing the more complex medical decision from the judicial domain and placing it within the remit of an expert administrative agency to accelerate judicial decision-making (J5 & J6).

We interpret this change as exacerbating medicalisation due to two reasons. First, because it has contributed to reaffirm the idea that the disability determination is to an important degree medical and exceed the legal field and expertise. This idea refers to a medicalised conception of disability and legal capacity. Second, because the administrative production of the evidence encapsulated in the Compin certificate – understood by the judges as containing the medical evidence – relieves the judge from the scrutiny of such evidence. This demands a degree of trust in the accuracy and authority of such evidence, which results in

excessive deference to medical assessments.

4.1.2. A medicalised conception of disability and legal capacity

The aim of those who defend some version of the social model of disability has been the demedicalisation of disability experiences, which can be conceived in broader non-medical terms. The medicalisation of disability—especially in the case of mental disability—has been a battlefield for both academics and the social movement of persons with disabilities. But, despite numerous efforts, the medical model of disability continues to dominate the domain of legal capacity determination, even in those countries in which the social model and a relational understanding of rights have had a strong impact (e.g., the UK) (B. Clough, 2015). Psychiatric evidence continues to be decisive and receives priority over other types of evidence, even when it is based on superficial knowledge of a person. This may depend on contextual factors such as the concrete regulation of legal capacity determination or the lack of engagement with persons with disabilities, but can also rest in the “illusion of certainty, objectivity and value free judgement and can provide much needed ‘closure’ for the family while also facilitating public confidence in case outcomes” (Case, 2016). This normally implies that other fields of expertise, lay evidence coming from family and carers who directly know the person, and crucially the will and preferences of the person whose capacity is being determined, are regarded as secondary sources of knowledge (Case, 2016; Fallon-Kund & Bick-enbach, 2016; Lindsey, 2019). The overreliance on medical evidence can be based on bias and stereotypes that are part of the legacy of the medical model (Flynn, 2015, pp. 107–108).

The results of our research show a highly medicalised understanding of both disability and legal capacity among the interviewed judges. Interviewees considered “disability” an organic condition to be determined by medical experts that, once detected, is insensitive to variations in different areas of social action (J3, J4, J5, J7 & J8). Additionally, despite being aware that the concept of “insanity” denotes a performance problem, the judges rely completely on medical diagnoses when making their decisions; therefore, they take for granted the connection between the medical and functional dimensions of disability. No social or contextual elements that can enhance or limit functionality were mentioned. This medical conception of mental disability impacted on the understanding of the statutory concepts of “insanity” and disability.

When asked whether the concept of “insanity” was a legal or a medical one, judges seemed to disagree. In general, they considered that “insanity” and “mental disability” are different medical terms and that “insanity” potentially requires a higher degree of disability. For instance, one judge says that insanity “is a technical concept therefore it must be supported by medics, a psychiatrist [but] the common sense says that [an insane person] is a person who has lost sense of reality, of time or space or of who he is”. He adds: “one is not able to determine what it is within medical typologies...[but the hearing] allows us to see whether the person knows his name, his age, his address or if he has lost sense of time, or if he speaks incoherently...obviously he is a person who will not be able to act on his own in the legal world” (J1). Another judge defines insanity as “an alteration in the mental faculties of a person to an important level that impedes her from discerning what is right or wrong” (J3). He adds that even though this is a legal concept, with the new scheme “it is no longer an issue that the judge determines because the law itself says...what percentage of alteration the person has to have [to be considered insane], so it became more objective” (J3). Another judge says that an “insane” person is someone who is deprived of their mental faculties “in a degree that does not enable him to develop, take care, of himself” (J4). According to him, this is a medical concept and it is determined considering the degree of mental disability set in the Compin certificate (J4). In another interview a judge argued that he sees insanity as referring to “an alteration of mental capacity that makes a person unable to locate himself in time and space...give incoherent answers or unable to answer questions” (J6). He explains that to assess insanity one has to determine if a person can fend for herself, be

autonomous, and act in the legal world – for example, entering into contracts with other people (J6). Lastly, a judge said that insanity refers to a person whose mental disability impedes her from understanding reality (J7), while another judge explains that insanity is related to a severe form of mental disability (J8). In contrast, some judges emphasised that the concept of “insanity” must have a legal dimension, since it would otherwise be inexplicable that the law requires judicial intervention (J2 & J5). However, it remained unclear what this legal dimension means in practice.

Judges’ medicalised view of disability also prevents them from identifying the changes in and nuances of the conceptualisation and regulation of disability. An example of this is the changes incorporated by the World Health Organization in relation to the recognition of a biopsychosocial model of disability, which resulted in a profound reform to the Compin assessment and certification process. This change, which was announced in 2012 as a major update of domestic regulations to match international disability standards and replace the medical-centred evaluation system in force since 1994, was entirely unknown to the judges. Ample knowledge of the content and scope of the CRPD and the statutory definition of disability of Law 20,422 according to the social model was also absent (J1, J2, J3, J6 & J7). For instance, one judge says that this procedure “is a mechanism that does not fail...it is not necessary to have recourse to the Convention because it is so clear that there is no need to make the issue normatively more complex” (J1). Their medicalised view of legal capacity means that judges rely heavily on the expert knowledge expressed in the Compin certificate for the determination of legal capacity. This poses a paradox: despite their highly medicalised conception of mental disability, judges inadvertently give great importance to a report produced by a partially demedicalised procedure such as the Compin assessment. Furthermore, they give limited importance to alternative evidence and show strong deference to medical expertise. The basis of this understanding is that judges lack the necessary tools to review a medical assessment under the evidence gathered in the hearing and must defer to specialised knowledge. Therefore, they entangle mental disability with insanity.

4.1.3. Deference to medical evidence

Excessive judicial deference to medical opinions is another factor increasing medicalisation. In the UK, Case (2016) showed that despite the Court of Protection (in England and Wales) claiming to have the final word on mental capacity assessment, this court is extraordinarily deferential to medical evidence and expertise. Notably, medical evidence is necessary to identify the impairment or disturbance required by the Mental Capacity Act 2005 (diagnostic threshold). However, excessive deference to medical evidence may be an indicator of the Court’s practices remaining medicalised, if such evidence sometimes replaces normative judgements for which psychiatric expertise is ill-equipped. The defence of the final judgment on legal capacity as the exclusive domain of the court has been a common feature in Court of Protection judgements, but similar defences can be seen elsewhere in cases in which medical expertise threatens to invade the authority of the court on issues that are ‘legal and moral determination, not clinical judgments’ (e.g. Tillbrook, Mumley, & Grisso, 2003). Case (2016) suggests the need for a robust “forensic scepticism”, expressed by favouring lay evidence over expert assessments and challenging expert evidence on normative grounds, or advancing non-pathological constructions of persons with disabilities’ behaviour as a way out of medicalised practices of legal capacity determination. Evidence from other jurisdictions suggests that multidisciplinary decision-making procedures lead to the consideration of a broader range of factors in determining legal capacity (Fallon-Kund et al., 2017, p. 6).

As shown, Chilean judges have a highly medicalised conception of mental disability. They are not specialists in mental capacity law, nor do they sit in multidisciplinary panels. These factors may contribute to explaining their attitude towards the “Compin certificate” as a piece of evidence. Chilean judges considered the Compin certificate as the key

piece of evidence. According to them, the certificate confirms that Compin has examined the person and concluded that the person has a disability, and the degree of disability (J1 & J3). The judges see their role in legal capacity determinations as a mere notary, who simply verifies a previous substantive assessment done elsewhere. Some of the judges understand the certificate as conclusive evidence of disability (J7 & J8). In fact, one judge says that the certificate is more than a hint, it is “determinative and, therefore, [the judicial process] is just paperwork because the decision necessarily is ready with the certificate” (J1).

While interviewees generally knew that this certificate is not the final proof of “insanity” in strictly legal terms, they believed that it is almost impossible for them to challenge it in practice (J5, J6 & J8). They believed that such designations are a matter for medical experts and are decided by Compin, who have an authority that goes beyond judicial competence (J1, J3 & J8). One judge puts it bluntly: “it has happened to me that I can have a good conversation with the person...but if Compin says that he has 70 or 80 per cent of disability the truth is that I am not going to ask for a reassessment. I, to be honest, trust what Compin says” (J8).

It is illustrative that one judge compares the certificate to an expert affidavit in relation to property boundaries conflicts, while another judge compares it to an expert affidavit in labour disability claims (J1 & J3). For instance, one interviewee said that “it is very difficult that one [...] could disregard that report, which is produced by impartial medical doctors, and that determines precisely the exact quantity, the percentage” of disability (J1). The same interviewee said that “facing a report by the State, by a specialised agency, by specialised people [...] to me at least, the thing is already decided” (J1). Another interviewee declared that he “feels that one has no competence to question this type of decision” and strike down the Compin certificate (J6). This reveals a high degree of deference to the medical opinion expressed by the Compin certificate on “disability”. Several interviewees mentioned that if the Compin certificate was to be questioned—or in the hypothetical case of a mismatch between the certificate and the person in the hearing—they would look for another medical opinion, typically from an expert witness or a re-examination by Compin (J5 & J8). However, no interviewed judge could recall being in such a situation.

Deference is combined with the interviewees’ lack of clear understanding of the Compin certificate as a piece of evidence. This is apparent in the fact that they were barely aware of the relevance of the degrees of disability required for their legal capacity determination. Although they knew that Compin establishes varying degrees of disability in their reports, they were unsure about the threshold for declaring a person “insane” (J1, J2, J4, J5, J6 & J8).

Moreover, the interviewees lacked understanding about how the Compin determinations are made. Most believed that it is a decision taken only by medics and consists of a series of examinations (J1, J2, J3, J4, J5, J7 & J8). None of the judges knew what types of tests were employed to determine disability. Moreover, they were unaware of the biopsychosocial approach of assessing disability used by Compin. The professions involved were also ignored since many of the judges believed that the team at Compin was composed exclusively of psychiatrists, neurologists and internal medicine doctors (J1, J2, J3, J4, J5, J7 & J8). Social care professionals such as social workers and even psychologists went unmentioned. It might be argued that the judges’ belief that the Compin determination was made by medics heightened their belief that the assessment was objective and about a biological condition.

Deference to expert knowledge has a profound impact on the self-understanding of the judicial role in the legal capacity determination process. This makes it difficult to identify a substantive legal task in determining legal capacity, thus making an activity that contains normative judgements into something entirely scientific and objective. The interviewed judges understood their role in the procedure in formalistic terms, which might explain why they rarely departed from the expert evidence. In relation to the Compin certificate they

understand their main role is to review its “legality”. By “legality”, they were referring to the formalities of the certificate. For example, one judge stated that Compin staff could have incorrectly written a number or made another similar mistake (J3). When asked about the possibility of challenging the assessment contained in the certificate, interviewed judges suggested that questioning the merits of the certificate would make the entire process longer, which could harm people in need (J5 & J6). One of the judges asked himself, “Could I fight or go against a certificate that was supposedly made by competent persons, who have the capacities to verify insanity? It is complicated” (J6). The only space to challenge the certificate is if it is obviously mistaken or if there is an apparent disagreement between the certificate and what the court sees in hearings (J1, J2, J4, J5, J7 & J8). For instance, one of our interviewees said that “as I am not a psychiatrist, I always give more value to the Compin certificate...in practice I have not experienced a case in which there was a divergence between the certificate and what I see” (J1). Since there is no established test or standard to be applied to the judicial review—something that the judges seem to expect if they are meant to carry out a more thorough review—judges act entirely intuitively and holistically, an approach that inherently favours bias against people with mental disabilities. Furthermore, the understanding of disability as an organic rather than a functional concept exacerbates this bias.

Our research shows that Chilean judges prefer objectivity and certainty over a complex or multidisciplinary conception of mental disability. One of the interviewees explains that judges “unfortunately, in these things work in binary terms, it is a yes-or-no question...one does not look at percentages, the percentage may eventually serve rhetorically for one of the parties but when you have to make a decision you will look...at the final result that the physicians provide” (J2). Since legal capacity is generally dealt with as an all-or-nothing issue in Chilean substantive law, the judges simply lack a full understanding of the complexity we are referring to, or the need for a more complex analysis of the available evidence. The problem with favouring objectivity and certainty is that judges consequently abandon their role as guardians of the presumption of capacity. They give up this role when they equate Compin’s certification of mental disability with a loss of legal capacity, thereby delegating legal capacity determination and showing very limited scepticism regarding the evidence contained in the certificate.

4.2. Participation: the hearing

Meaningful participation of persons with disabilities is a critical aspect of the debate on legal capacity determination (Case, 2019; Fallon-Kund & Bickenbach, 2016; Lindsey, 2019; Series, 2014; Series et al., 2017) and a key demand of disability activists (Flynn, 2015, Chapter 4). A number of reasons support the need to secure participation, including human rights commitments (Fallon-Kund & Bickenbach, 2016, p. 29; Series, 2014), improvement of the quality of decision-making (Donnelly, 2009, p. 12; Fallon-Kund & Bickenbach, 2016, p. 30) and acceptance of the decisions by the persons involved (Fallon-Kund & Bickenbach, 2016, p. 33; Lindsey, 2019, p. 452), among others.

In jurisdictions in which participation is viewed as an important value, the practice of legal capacity determinations may depart from normative commitments. For instance, in England and Wales the Mental Capacity Act (MCA) 2005 is an explicitly value-based piece of legislation, supposedly designed to empower people through consideration of their autonomy. Writing about that jurisdiction, Kong, Coggon, Dunn, and Cooper (2019) noted the normative importance of the participatory element in procedures before the Court of Protection, thereby highlighting the instrumental and dignitary value of participation. However, in practice the personal participation of a person subject to proceedings may be less important than it seems. Recently, Lindsey (2019) supported this view with empirically-grounded research about participation in the Court of Protection (CoP). She argued that in procedures before the CoP, the person with disabilities was usually absent. This deficit negatively

impacts the achievement of the instrumental and non-instrumental benefits of participation. Furthermore, Lindsey (2019) claimed that this feature of the process constitutes a form of “testimonial injustice”, since the person with disabilities is excluded as a relevant source of evidence or knowledge (see also Case, 2019).

Using the language of the European Court of Human Rights (ECtHR), the literature has established the idea of the “rule of personal presence” to describe the need to eliminate certain barriers that deprive people of their right to participate in proceedings in which their capacity is under discussion (Series, 2014; Series et al., 2017). Also echoing the judgments of the ECtHR, a set of normative components, summarised as an “equal and effective right to be heard”, have been said to include the right to be heard and legally represented and/or supported by a person of trust, and a set of procedural accommodations (e.g. most favourable setting, multidisciplinary authority or mandatory training of the judges) (Fallon-Kund & Bickenbach, 2016).

Against this backdrop, the Chilean fast-track procedure seems promising with regard to enhancing participation, because it requires the judge to conduct a hearing in which the presence of the person with disabilities is mandatory. This was explicitly introduced in the legislative debate to counteract the weight of the Compin certificate, suggesting that it is not enough to hear the expert evidence, since the judge must directly see and hear the person with disabilities. However, these hearings are affected by serious flaws. As a result, they only seemingly secure the right to be heard and the principle of participation. In practice, the hearings serve the function of seeing the person with disabilities and verifying the identities of the petitioners bringing the case to court, rather than being a forum for engagement with the person with disabilities. This has an impact on the hearing’s potential function of balancing, contrasting and questioning forensic evidence; but perhaps more seriously, it exacerbates the lack of participation in the procedure of the persons whose legal capacity is being questioned.

Our research highlights two practical drawbacks in guaranteeing the participation of the person whose legal capacity is being determined. First, because the person with disabilities is not legally considered to be a party in the process, the interviewed judges considered the relatives of the person with disabilities as the main actors. Second, we found a complete lack of accommodations for effective participation and third-party support. These problems further marginalise persons with disabilities in the legal process, since they are viewed as objects rather than subjects. The subjective element – their voice, perspective on the world, will, preferences and interests – is completely ignored by the court.

4.2.1. *The petitioner as the main actor of the procedure*

According to the interviewees, the petitioner is usually a relative who needs to be appointed guardian in order to complete legal and social security paperwork on behalf of the person with disabilities (J3, J4, J5, J6 & J8). Although questions during these hearings are directed at the person with disabilities, petitioners play a crucial role during the entire procedure (including the hearing). To begin with, the interviewed judges mention that they “bring” the person to the tribunal. One judge, for instance, said that “always the procedure is initiated by the person who requests to be named guardian” (J7).

The interviewed judges said that, in addition to meeting the person with disabilities, the hearings allow them to see who the petitioner is and how close their relationship is with the person in question (for instance, J6 & J8). Many interviewees highlighted that the persons on whose behalf the legal capacity processes are initiated are typically young people just coming of age (and thus needing to be represented as an adult) or old people who cannot care for themselves (J5 & J8). In the descriptions of the interviewees, a standard case involves an old person with some form of dementia or similar problems accompanied by a daughter or son who takes care of her or him (J4 & J5). Only after being questioned did some interviewees admit that young people were also sometimes subjected by this procedure. In the latter type of case, the petitioners are often parents (J5). Interviewed judges express distrust if

they perceive that the petitioner does not have a close relationship with the person with disabilities (e.g. if they do not live together). One judge said that “when it is the father or the mother of the potential interdict, in reality, I have neither many doubts nor suspicion that third parties could be aggrieved, but I do become suspicious when the petitioners are other relatives. Then you wonder what the purpose of this person is [...]” (J3). This is a common attitude among the judges, and reveals a certain apprehension that the procedure could be used to damage third parties, yet not the person being examined.

In fact, the non-adversarial nature of the procedure seems to make judges uncomfortable. Several judges wondered why the entire “insanity” determination was not made administrative instead of judicial (J1, J3 & J8). One judge claimed that “the ‘insanity’ [could be established] with the Compin certificate, or they could give [...], a document, the Compin certificate will be enough. [...] But the guardianship, I don’t know if you could do that through the administrative way” (J6). This shows that, according to most interviewees, the main issue amenable to judicial determination is impartial adjudication if a disagreement occurs among family members regarding who should be appointed as guardian (J3, J5, J6, J7 & J8). A couple of interviewees believed that the procedure should include the participation of other family members who may eventually be affected by the outcome (J3 & J5). When the petitioner was not the parent or child of the person with disabilities, some interviewees invited other relatives to a special hearing (J3 & J5). One interviewee stated that “the importance of this is not so much the declaration of ‘insanity’, but the appointment of a guardian. It is there where disagreement happens, since the law does not say that there must be a hearing with relatives” (J5). This judge also believed that the legal representation of people with disabilities “would be more cumbersome because, actually, there are few cases in which you see [that the purpose is] to harm them economically, [the actual risk is rather] to harm the siblings” (J5). By this, the judge implied that the procedure may adversely affect other family members while not impairing the rights of the person with disabilities. Only one judge mentioned that a critical aspect of this process is the lack of legal representation of the person with disabilities (J3).

Comparative literature has mentioned the insufficient attention given to a possible conflict of interest between the relatives requesting incapacitation and the person whose capacity is to be determined (Series, 2014, p. 121). In Chile, this goes beyond a lack of consideration for the will and preference of the person with disabilities, since their best interests are not even represented. In practice, the person is never asked to consent to participate in or attend the hearing, nor are they informed of the consequences of any court decisions. The petitioner assumes the representation of all interests at stake: their own and those of the person with disabilities. One of the judges, for instance, reported that in the hearing she asks the petitioners if they “understand the procedure being conducted, what is the effect of the declaration of interdiction, and the effect of the fact that they will be appointed guardian and will be in charge of administering the goods of the interdicted” (J8). They also take all the decisions within the procedure. As will be mentioned, judges only identified a legal problem when the interests of third parties—typically those of other relatives—are potentially affected.

4.2.2. *Engagement*

Persons with disabilities’ lack of *locus standi* may also explain the absence of the attitudes, measures, and accommodations to make their voices heard during the hearing. Commenting on the difficulties faced by persons with disabilities in participating before the CoP, the literature has identified various “communicative, accessibility, and logistical issues” (Ruck Keene, Bartlett, & Allen, 2016). In a comprehensive study about these difficulties, Series et al. (2017) highlight among other problems “a lack of recognition of the centrality of P’s ‘personal presence’ in proceedings in the CoP’s rules and guidance; a lack of provision for special measures and reasonable adjustments in the CoP’s rules, as well as no specific allocation of resources for this purpose; inadequate

training of legal representatives and judges on disability and access to justice matters; a lack of accessible information about the CoP for those who are subject to its jurisdiction". All of those problems impact on the participation of the person whose capacity is being assessed, whose personal presence before the CoP is rare (see also [Case, 2019](#)).

Despite their mandatory presence, the Chilean procedure is not designed to facilitate the judge's engagement with the person with disability. There is a complete lack of measures to promote effective, alternative or facilitated communication, support from third parties, or the adaptation of procedural rules to accommodate the person's testimony. This may be explained by the fact that the judges attend the hearing with the assumption that the person is "insane", despite the fact that there is a legally binding presumption of capacity. In this regard, the function of the hearing in relation to the person with disabilities is to rule out a gross mismatch between the Compin certificate and what the court sees at the hearing (J1, J2, J3, J5 & J6).

Some practical features of the hearing show that the presence of the person with disabilities is not taken as a relevant element in the process, confirming a "failure to value a person in their 'capacity as a giver of knowledge'" ([Lindsey, 2019](#), p. 451). Three examples may illustrate the point. First, some judges do not conduct such hearings directly. Some of the interviewed judges participate in the hearing (J5 & J7), while other judges delegate this task to subordinates (J4 & J6). This implies that judges do not always have a proper interaction with the person in question before making a decision. Second, the judge meets the person with disabilities in the tribunals' premises, which are not adapted to proper hearings (J2 & J8). In this regard, no accommodation and special support measure were mentioned by the interviewed judges, beside the fact that the hearings can also take place in a person's home under exceptional circumstances. But even in cases where the hearing takes place in the person's home, judges take that decision due to the fact that bringing the person to the court premises could be too costly for the petitioner or impossible due to mobility challenges (J3, J4, J6 & J8). Therefore, these hearings take place at the person's home to make life easier for the petitioner, not to provide a less intimidating setting for the person with disability. In fact, none of the judges mentioned making the person with disabilities more comfortable with the procedure when discussing factors relevant to adopting this measure.

Our third and final example relates to the lack of standardised and appropriate interview protocols to guide these hearings (J2 & J6). The hearings are brief and informal, lasting approximately 10 min on average (J3, J5 & J8). Currently, such hearings are conducted intuitively, without an awareness of the position of the person with disabilities. Although they are not included in a formal protocol, all interviewed judges asked similar questions related to time and space in hearings (For instance, J1, J4, J5, J6, J7 & J8). The hearings usually start by asking the person about their identity (e.g. name and age), the time, the current season, the people accompanying them, and so on. When the court staff are conducting the hearing and the person can reply to these questions, they might call the judge or—more commonly—may later point out that something strange occurred in the hearing when the judge examines the written file (J4 & J6). According to most interviewees, the cases in which the hearing reveals a person who does not seem mentally disabled are extremely rare (J1, J3, J4 & J7). Most of the interviewed judges could not remember a single case in which they detected a disagreement between the disability certificate and what was observed in the hearing.

The absence of accommodations is symptomatic of the lack of engagement with the person with disabilities and the prejudices against persons with disabilities whose legal capacity is being discussed. For example, it reveals a dangerous lack of understanding of the nature of certain disabilities that can limit communication but leave decision-making capabilities untouched. Overall, interviewees mentioned that they usually expect – and see – people in very poor health condition (J5 & J6). According to many interviewees, most persons with disabilities experience considerable difficulty when communicating with judges or

have a poor understanding of time and space (J4, J5, J6 & J7). When a person appears able to communicate and seems aware of time and space, judges scrutinise their behaviour more intensely, since this is not typical. Frequently, judges appear to collapse communication problems into mental disability difficulties (J5 & J7). If a person cannot express their ideas, that is taken as evidence of serious mental disability (J5 & J7).

To conclude, it is important to emphasise that the regulatory setting in which the judges operate prevents them from critically scrutinising the evidence and engaging meaningfully with persons with disabilities at hearings. In our interviews, we found judges were highly interested in disability rights and sensitive to the difficulties of persons with disabilities' access to justice. Yet their institutional position undermines these principles in these types of cases. In fact, they receive the legislative message that these procedures must be agile because social benefits depend on it. Additionally, the evidence provided by Compin is insufficient to give the judges a multifaceted view of the situation of persons with disabilities. The Compin certificate is excessively focused on a figure that signals a supposedly objective "degree of disability", without highlighting non-medical factors that may be of relevance for legal capacity determinations. Finally, the procedure, the infrastructure and the legal training of these judges are primarily concerned with economic private law affairs and, predictably, they seem inadequate for legal capacity cases.

5. Conclusion

In this paper, we have examined the current system of legal capacity determinations in Chile. We have investigated the legal regulation of procedures and how they are conducted in practice. Our primary aim was to highlight the institutional and procedural aspects that are sometimes overlooked in debates about the legal capacity and rights of persons with disabilities. This paper reveals that the Chilean model has two interesting institutional features: its heightened medicalisation and its approach to the need for participation.

Regarding medicalisation, the Chilean model is distinctive in the way that medical evidence is introduced in the process. Instead of creating a specialised court or establishing a multidisciplinary panel, the 2004 reform decided to use expert assessments made by an administrative agency for social security purposes as the primary evidence for judicial determinations of legal capacity. The problem is that this reform was implemented without proper reflection. The main driver for this reform was not the need to better process complex information about a person with disabilities; instead, the main driver was the need to speed up a lengthy judicial process. As a result, judges generally have a poor ability to discern the weight they should afford to evidence from the expert agency. While they exercise strong deference on epistemic grounds, they exhibit a sometimes-striking lack of understanding of the meaning of the evidence and the process of its production when challenged on their understanding of the scope and details of the agency assessments. Additionally, this piece of evidence itself is a very brief form that only indicates whether a person is considered within the category of persons with disabilities and the degree of their disability. Therefore, this certificate does not show a complex understanding of the person under assessment, obscuring many factors and silencing other relevant perspectives about their disability. It also offers little guidance for judicial determinations. The results of our study suggest that blind externalisation of the evidence-gathering element of the procedure was undesirable.

In terms of participation, the Chilean model takes an interesting approach by incorporating a mandatory hearing into the judicial process, in which the judge is expected to meet and hear the person with disabilities. This offers an attractive opportunity to obtain the benefits of participation. However, in our interviews, we found that the hearing is not the core of the process, as we might have expected. Also, the hearing is very brief and the judges often do not participate directly. Instead, usually a clerk uses a makeshift questionnaire to interview the person

with disabilities. The hearing essentially serves two purposes: (1) to detect a gross mistake by Compin when the person ostensibly appears not to have a mental impairment and (2) to ensure that close relatives who are to be appointed guardians have a close relationship with the person with disabilities who will be declared “insane”.

To remedy this, future regulations need to be put in place to ensure that judges view persons with disabilities as the main individuals affected by such decisions, and engage with them accordingly. Greater emphasis must be placed on hearing directly from those who experience disabilities, instead of excessively relying on medical expertise. Moreover, persons with disabilities must be legally represented. Representatives must be real litigation friends that hear their preferences and desires and do not merely act in their best interests (Ruck Keene et al., 2016). Ultimately, a crucial function of the legal process related to legal capacity must be offering a forum for the voices of persons with disabilities to be heard, instead of merely serving as a bureaucratic process to determine the credibility of medical evidence and the sincerity of prospective guardians.

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